Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers participating in the Virginia Medical Assistance, FAMIS, and SLH Programs, and Managed Care Organizations

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO Special

DATE 5/1/2003

SUBJECT: Implementation of the New Virginia Medicaid Management Information System (MMIS)

This is the final in a series of Medicaid Memos introducing the Department of Medical Assistance Services' (DMAS) new Medicaid Management Information System (MMIS). The new MMIS will provide significant enhancements to better serve our customers, but it will require procedural changes in some areas in order to take advantage of these enhancements. The purpose of this memo is to communicate these changes so that providers can prepare for the transition from our current system to the new MMIS. Additional details will be provided at our upcoming provider training session and in updates to the provider manuals. Also, please watch for updated information in the form of Remittance Advice (RA) messages and updates to the websites listed in this memo. Copies of this Medicaid Memo can be viewed and downloaded from the DMAS website at http://www.dmas.state.va.us.

We apologize for the length of this memo and the amount of information contained in it. However, we are requesting that you take the time to review it carefully, as it contains important information regarding enhanced enrollee eligibility verification options, billing changes and revised claim forms, one-time impacts as we transition to the new MMIS, and HIPAA compliance. **To assist you in locating information of special interest to you, an index of key information is attached as the last page of this memo**.

The official implementation date of the new MMIS is June 20, 2003. However, you will begin to see impacts prior to that date as we make the transition. Although DMAS has made every attempt to minimize impacts on the provider community and make this transition as smooth as possible, certain impacts are unavoidable, and we want to communicate these in advance so that preparations can be made.

HIPAA READINESS

As communicated in previous Medicaid Memos, the new MMIS will be fully HIPAA compliant when it is implemented on June 20, 2003. Use of the standard HIPAA Transaction Sets and National Codes will be optional until October 16, 2003, at which time, HIPAA formats will become mandatory for all electronic claims. At this time, DMAS is conducting HIPAA testing with trading partners. If you have not yet scheduled testing and are ready to do so, please visit our fiscal agent's, First Health Services Corporation (FHSC), website at http://virginia.fhsc.com. This website contains all of the information needed to schedule and begin conducting the testing. Also, please refer to our Medicaid Memo dated March 26, 2003, for detailed information on this subject. That, and other new MMIS-related memos, can be found on the DMAS website at http://www.dmas.state.va.us.

As a reminder, DMAS will not accept Local Codes for claims, either electronic or paper, with dates of service on or after October 16, 2003. If you submit claims using Local Codes with dates of service on or after October 16, 2003, the claims **will be denied**. DMAS has established a crosswalk to assist you in determining the appropriate National Codes to use in replacing Local Codes. This crosswalk can be viewed on the DMAS website at http://www.dmas.state.va.us.

PROVIDER ENROLLMENT

You will not have to take any action at this time regarding your enrollment to participate in programs administered by DMAS, **with the possible exception of certain Temporary Detention Order (TDO) providers**. However, the new MMIS is equipped to include additional information regarding you and your practice, and this information will allow us to provide you with better service. After the new MMIS is implemented, we will be mailing new provider enrollment packages to all providers. Execution of the revised forms is necessary in order to fulfill HIPAA requirements and provide DMAS with the additional information needed to improve program operations.

Please note the information below if you participate in the State and Local Hospital (SLH), Family Access to Medical Insurance Security (FAMIS), or Temporary Detention Order (TDO) Programs.

- Provider numbers for the SLH, FAMIS, and TDO Programs will be the same as the numbers assigned for the Virginia Medicaid Program. DMAS will be able to identify the appropriate program being billed based on the enrollee's eligibility.

- If you are a provider billing for TDO services and you are not enrolled as a Virginia Medicaid provider, you must enroll as a provider in the TDO Program. Upon enrollment, you will be assigned a provider number. You will no longer be able to bill using your FEIN or Social Security Number.

Additional information of interest to SLH providers is included as Attachment 1 to this memo.

ENROLLEE ELIGIBILITY VERIFICATION OPTIONS

One of the most significant enhancements of the new MMIS is the availability of additional automated options for use by providers in verifying enrollee eligibility and the provision of more detailed information related to eligibility, claims, and check status.

One of the first changes you will see is the introduction of permanent, plastic enrollee identification cards. The new plastic cards will replace the current paper cards and will no longer require reissuance on a monthly basis. As we make the transition to the new MMIS, the normal paper cards will be issued to enrollees in June 2003 for the month of July 2003. In early July, enrollees will be issued plastic cards, so there may be some time period in July during which enrollees may have both a paper and a plastic card in their possession. This is a safeguard to ensure that enrollees have an identification card of one form or another during the transition period. Both cards will be valid, and you may accept either one through July 31, 2003. **After July 31, only the plastic cards can be accepted**.

The plastic identification cards offer another important enhancement. The cards are equipped to use "swipe-card technology" and will be encoded with data that will allow you to electronically verify eligibility and receive other information of interest to you. To take advantage of this technology, you will need to contract with an eligibility vendor. There will be some cost to you for this service.

The eligibility vendors are as follows:

ProxyMed Inc./MedUnite	(804) 965-6198
HDX	(610) 219-1701
Medifax	(800) 444-4336, ext. 2794
WebMD/Envoy	(941) 575-0632
PayerPath	(804) 560-2400
NDC	(724) 935-5690

There are other eligibility options that are available at no cost to you. The automated voice response system, which will be known as **MediCall**, will continue to be available, and it will provide more information than is currently available, including information on pre-authorizations and service limits. The **MediCall** telephone number will be printed on the back of the plastic ID cards. This number is in addition to the current voice response system telephone number, which will remain active.

In addition, DMAS will be introducing a new web-based option for enrollee eligibility verification and claim status information, known as the Automated Response System (ARS). This option is also available free-of-charge, and the information is available in a real-time mode. Information on signing up for this option will be available on the FHSC website at http://virginia.fhsc.com beginning on June 2, 2003. The ARS is secure and fully HIPAA-compliant. When you sign up to use the ARS, you will be given a password for use in obtaining the necessary information. Staff at FHSC will be available to assist you in signing up to use the ARS and to help with any questions you may have.

These three eligibility verification options will all provide you with the same information. They are designed to give you quick access to current information, even during non-business hours, at little or no cost to you.

BILLING INSTRUCTIONS AND CLAIMS INFORMATION

Special Billing Instructions for SLH Providers. Please see Attachment 1 to this memo for special billing instructions applicable to SLH providers.

Expanded Field Sizes. A number of fields in the new MMIS will be expanding in order to allow for flexibility for future changes. They are as follows:

Provider Identification Number	Expanding from 7 to 9 digits. If you have already been assigned a 7-digit number, you will continue to use that number.
Claim Reference Number (ICN)	Expanding to 16 digits.
PA Number	Expanding to 11 digits.
PA Action Reason Codes	Expanding to 4 digits.
Adjustment/Void Reason Codes	Expanding to 4 digits. The current "5" will be replaced by a "10" and the last 2 digits will remain the same, e.g., 552 will become 1052.
Error Reason Codes	Expanding to 4 digits. Error Reason Codes will appear on the Remittance Advice (RA). In addition, new error messages have been added to the RAs, incorporating the National Standard EDI Adjustment Codes and Remark Codes. There will be a transition period during which both the DMAS proprietary error reasons and the National Standard Reason and Remark Codes will be printed on the paper RA.

CMS-1500 (12/90) Claim Form. The following are new instructions for completion of certain fields on the CMS-1500 claim form:

- **Block 24G.** Minutes billed should be specified in the "days or units" field only. Do not bill fractional hours.

- **Block 33.** Enter the Virginia Medicaid provider servicing number in the PIN# field and the billing provider number in the GRP# field. If the servicing and billing providers are the same, leave the GRP# field blank. Also, ensure that the provider numbers are distinct and separate from the telephone number or zip code.

- **HMO Copayments.** When billing for the copayment for Medicaid enrollees who have a Health Maintenance Organization (HMO) as their primary insurer, use COB code "3" in locator 24J. **Do not enter an amount in locator 24K. "HMO Copay" must be entered in locator 11C.** The amount billed to Medicaid in Block 24F (Charges) must represent only the enrollee's copayment

amount for the HMO, and the Explanation of Benefits (EOB) must be attached. **Use the CPT or HCPCS procedure code that was billed as the primary procedure to the HMO.** This does not apply to enrollees in a Medicaid HMO, e.g., Medallion II. The Medicaid copayment amount will apply to office visits. Therefore, a Medicaid copayment will be deducted from the HMO copayment billed. For example: A Medicaid enrollee with HMO primary insurance may have a $10.00 copayment for an office visit. Medicaid's copayment for the office visit is $1.00. Therefore, Medicaid's allowance will be $9.00 for this office visit. The remaining $1.00 should be collected from the enrollee at the time of the service. For electronic data interchange (EDI) claims filers, please refer to the EDI companion guide. Companion guides can be found on the FHSC website at http://virginia.fhsc.com.

UB-92 (CMS-1450) Claim Form. Changes for claims submitted on the UB-92 are the result of changes made by the National Uniform Billing Committee (NUBC). They are as follows:

- Revenue codes have been expanded to 4 digits. Providers should submit the appropriate revenue codes for the services provided. The revenue codes accepted for each provider class type will be attached to their specific provider manual billing updates. Leading zeroes must be inserted in 3-digit codes that have not been expanded by the NUBC.

- Bill types that indicate a claim adjustment will no longer be indicated by the third digit of "6" (e.g., 116, 136). The appropriate third digit is "7" (e.g., 117, 137).

- DMAS will accept all standard National Codes from CPT/HCPCS, ICD-9-CM for diagnosis, procedure, condition, and occurrence codes.

- Services (inpatient admissions, rehabilitative services, home health) that require pre-authorization (PA) must have the assigned PA number included on the claim. The PA number is placed in locator 63. **Claims will be denied if a PA is required for the service, and the number is not included on the claim.**

In addition, the following changes apply to nursing facilities:

- The bill types for Intermediate Care Facilities will change from 811 (original), 816 (adjustment), and 818 (void) to 611 (original), 617 (adjustment), and 618 (void).

- The patient status codes for locator 22 will be changed to accept standard National Codes. The frequently used status codes are listed below. Please refer to the NUBC manual for a complete listing.

01 = discharged to home or self care.
02 = discharged to another short term general hospital for inpatient care.
03 = discharged/transferred to skilled nursing facility (SNF).
04 = discharged/transferred to intermediate care facility (ICF).
05 = discharged/transferred to another institution for inpatient care or referred for outpatient services to another institution.
07 = left against medical advice or discontinue care.
20 = expired.

The **Comprehensive Services Act (CSA) Reimbursement Rate Certification form** (DMAS 600) has been revised. It is available for download from the DMAS website at http://www.dmas.state.va.us.

Title XVIII (Medicare) Deductible and Coinsurance Invoice Form. DMAS has revised its Title XVIII (Medicare) Deductible and Coinsurance Invoice form (DMAS – 30 R 6/03). The revised claim form will allow submission of claims for one recipient per form only. The new form will facilitate the data entry process and increase the accuracy of claims processing. This, in turn, should significantly reduce errors and speed claims payment. This form is specific to the Virginia Medicaid Program, and other Title XVIII claim forms will not be accepted. **The revised claim form must be used for all paper claims postmarked after May 30, 2003. However, do not use it before that date. Do not use any existing claim forms that you may have in your stock after this time. The only claim form that will be accepted for claims postmarked after May 30, 2003 is the DMAS-30 R 6/03.** An example of this form is included in Attachment 5 to this memo. It is available for downloading from the DMAS website at http://www.dmas.state.va.us. The current Title XVIII Adjustment Form (DMAS-31) will continue to be used for adjustments.

Claims Turnaround Documents. A turnaround document (TAD) will replace the blue reject letters currently sent by FHSC. If a claim cannot be processed due to missing or invalid data on the claim submitted, you will receive a system-generated TAD. The TAD must be returned to FHSC with the requested information. The claim will be denied if the TAD is not returned and corrections entered in the system within 21 days. Please allow sufficient time for entering corrections into the system (48 hours) and mail time when returning TADs. Only the requested information should be returned. Additional information will not be considered and may cause the claim to be denied. A sample of the new TAD is included in Attachment 5 to this memo.

Electronic Billing Attachment Form. A new attachment form (DMAS-3) will be available for use by electronic billers **only** to submit a non-electronic attachment to a claim submitted electronically using the X12N 837 claims transaction. An Attachment Control Number (ACN) must be entered on the electronic claim submitted. The ACN consists of the combined fields of the patient account number, date of service, and the sequence number. (See the FHSC website at http://virginia.fhsc.com for electronic claim transmission specifications). **IMPORTANT:** THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM, OR THE ATTACHMENT WILL NOT BE MATCHED TO THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, THE CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM

WITHIN 21 DAYS, OR THE CLAIM MAY RESULT IN A DENIAL. PLEASE ALLOW SUFFICIENT TIME FOR ENTERING DATA INTO THE SYSTEM (48 HOURS) AND MAIL TIME WHEN SUBMITTING THE DMAS-3. A sample of the DMAS-3 is included in Attachment 5 to this memo. Copies of the DMAS-3 may be downloaded from the DMAS website at http://www.dmas.state.va.us.

Maternity and Infant Care Coordination Record. The current Maternity Care Coordination Record (DMAS-50) and the Infant Care Coordination Record (DMAS-51) have been combined into a single form now known as the Maternal and Infant Care Coordination Record (DMAS-50 rev 06/03). Detailed instructions on completing this form are printed on the back of the form (copy included in Attachment 5 to this memo). For your convenience, elements that apply to both maternity and infant clients are in regular typeface. Elements relating only to maternity clients appear in *italics*. Elements relating only to infant clients appear in **Bold**. There is no change in the process for submitting your admission packets, Outcome Reports, and change forms. You must begin using the new Care Coordination Record on May 30, 2003. The new DMAS-50 may be downloaded from the DMAS website at http://www.dmas.state.va.us.

The BabyCare program is now part of DMAS' Division of Health Care Services. To ensure prompt attention to your paperwork, please direct information to:

BabyCare Program
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, VA 23219

Do not send claims to the above address. Claims should always be sent directly to FHSC. Sending claims to the above address increases the time it takes to process your claims.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that have dental clinics associated with them, the Local Code 00088 will no longer be valid for claims with dates of service on or after October 16, 2003. For claims with dates of service on or after October 16, 2003, bill Medicaid using one of the standard Current Dental Terminology (CDT-4) codes (either D0120 or D0150) for dental examinations. You will continue to bill the dental visit "encounter" on the American Dental Association claim form, ADA (1994) Claim Form.

Emergency Transportation Providers. Local Codes that begin with "Y" will no longer be valid for claims with dates of service on or after October 16, 2003. For claims with dates of service on or after October 16, 2003, bill Medicaid using the following crosswalk:

Local Code	**New HCPCS Code**
Y0109	A0225
Y0110	A0427

Y0110	A0429
Y0121	A0430, A0431, or A0999

Vaccine Billing Information. Effective for claims with dates of service on or after October 16, 2003, you will no longer use the Local "Y" Codes when billing Medicaid for the administration fee for vaccines provided under the Vaccines for Children (VFC) Program. Claims with dates of service on or after October 16, 2003 must be submitted with the Current Procedural Terminology (CPT) code that describes the vaccine provided. For a vaccine provided to a Medicaid child, you should use the applicable CPT code to reflect the administration fee and bill $11.00 for the charge. You will be reimbursed $11.00. For a vaccine provided to a FAMIS enrollee, you should also bill the CPT code, but your charge should reflect both the acquisition cost for the vaccine provided **PLUS** the $11.00 administration fee. For these enrollees, you will be reimbursed the lesser of the most current acquisition cost plus $11.00 or actual charges for these enrollees.

Providers must use Current Procedural Terminology (CPT) codes when billing for either the administration fee or acquisition cost (FAMIS enrollees only) for vaccines. When a CPT code is billed to reflect a vaccine provided under the VFC program to a Medicaid enrollee, an $11.00 administration fee will be paid regardless of the CPT code billed. NOTE: It is **extremely important** to bill the correct CPT code that reflects the vaccine provided, as this assists the Virginia Department of Health (VDH) with their accountability plan which is required by the Centers for Medicare and Medicaid Services (CMS). For FAMIS enrollees, in addition to the $11.00 administration fee reimbursement, you will also be reimbursed the most recent acquisition cost that DMAS has on file for the vaccine.

Example 1: You are billing Medicaid for a Hepatitis B vaccine provided to a child covered under the VFC Program. Use code 90744. Payment will be $11.00 (administration fee only).

Example 2: You are billing Medicaid for a Hepatitis B vaccine provided to a child covered under the FAMIS Program. Use code 90744 (bill only one line). Payment will be the lesser of the most recent acquisition cost on file **PLUS** the $11.00 administration fee, or actual charges.

NOTE: For FAMIS enrollees and for other enrollees ages 19 and 20, physicians will be reimbursed an appropriate minimal office visit (e.g., CPT code 99211) in addition to the administration fee and/or acquisition cost as appropriate when an immunization is the only service provided.

For questions concerning the VFC Program, please contact VDH, Department of Immunizations, at 1-800-568-1929.

Ambulatory Surgical Centers. The facility fee for the use of the Ambulatory Surgery Center (ASC) should be billed by using the Current Procedural Terminology (CPT) code that describes the surgery performed. Medicaid is using the most recent ASC group listings as defined by Medicare. For the most recent listings, see the Medicare website (www.cms.gov). If you are billing for a procedure that is

not included in these listings, your claim will pend and will be manually reviewed for payment. Remember that the fee that is reimbursed to ASCs is for facility use and necessary equipment only. The physician performing the surgery will be reimbursed separately by billing the CPT code that describes the surgery performed. The reimbursement rate for physicians is based on the Resource Based Relative Value Scale (RBRVS). The reimbursement rate for facilities is based on fees established by DMAS. Your payment will be determined based on the ASC Group in which the procedure falls. See the crosswalk chart below:

Crosswalk from Previous "M" Codes to ASC Group Listings

Old Code	ASC Group	Payment to Facility
M0050	Group 1	$277.44
M0051	Group 2	$371.52
M0052	Group 3	$426.05
M0053	Group 4	$524.83
M0054 (formerly used as an unlisted code for surgeries not found in other ASC Groups)	Group 5	$599.14
No previous code	Group 7	$869.14

NOTE: While Medicare has established a payment rate for ASC Group 6, there are no procedures that fall under this group at the present time.

If you are billing for two surgeries performed on the same day that fall under the same ASC Group Listing, Medicaid will reimburse the facility-use fee at the rate of 100 percent for the first surgery and 50 percent for the second surgery. If you are billing for surgeries that fall under different ASC Group Listings, the ASC will be paid 100 percent of the facility-use fee for the surgery with the higher payment level and 50 percent for any additional surgeries.

Optical Character Recognition. FHSC utilizes Optical Character Recognition (OCR), a technology which permits the recognition and capture of printed data. Through the use of OCR, claims are entered into the processing system more rapidly. In addition, OCR minimizes manual intervention required to correctly process claims. Successful scanning begins with the proper submission of claims data. Printed characters must conform to pre-programmed specifications relative to character size, density, and alignment on the CMS-1500 (12/90) and UB92-1450 forms. Only the original CMS-1500 (12/90) and UB92-1450 forms with the proper red dropout ink (PMS# J6983) are acceptable for OCR (Optical Character Recognition). Guidelines to ensure proper processing of paper claims submission are included in Attachment 2 to this memo. Adherence to these guidelines will increase the accuracy of claims processing and facilitate claims payment. Handwritten claims forms are still acceptable, but the processing time for these claims may be increased.

MEDICAL PRE-AUTHORIZATION PROCESS

Pre-authorization (PA) is required for a number of services that are reimbursed by DMAS. Implementation of the new MMIS will impact the medical pre-authorization process. Where noted, there will be attachments for your records and use. The following sets forth the most significant changes to the PA process:

- PA numbers will be expanded from 9 to 11 digits. The PA number is **required** on the claim form when billing for an authorized service.

- PA Action Reason Code numbers will be expanded from 3 to 4-digit numerical codes followed by the reason code narrative.

- If you are requesting pre-authorization utilizing the "paper" process for services such as DME and supplies, home health, and outpatient rehabilitation, you must utilize the revised DMAS-351 R 06/03 form for requests postmarked after May 30, 2003. Supporting medical documentation should be attached to the completed form when submitting an original or change request. You may also request a PA cancellation utilizing the DMAS-351. A copy of this form, with instructions for completion, is included in Attachment 5 to this memo, and it is available for downloading from the DMAS website at http://www.dmas.state.va.us. Use the revised DMAS-351 form only for claims postmarked after May 30, 2003. Attachment 3 to this memo contains a listing of PA Service Types that are needed to complete this form.

- When additional supporting documentation is required in response to a "pend" response message, you must utilize the new DMAS-361 form as a cover sheet for the documentation. The DMAS-361 form can also be used to request reconsideration of a PA denial. Please refer to the appropriate provider manual for required reconsideration timeframes for submission. A copy of the new DMAS-361 is included in Attachment 5 to this memo, and can be downloaded from the DMAS website. Use the new DMAS-361 form only for claims postmarked after May 30, 2003.

- **Effective July 1, 2003, PA will be required for home health skilled nursing and home health rehabilitation, as well as rehabilitation services, including physical therapy, occupational therapy, and speech therapy, prior to the sixth visit. If authorization is not obtained prior to the sixth visit, authorization will not be retroactive.**

- **Effective July 1, 2003, service limits for outpatient psychiatric services in the first year of treatment will decrease to 5 visits. Prior to sixth visit, the provider must contact DMAS to obtain authorization for additional therapy sessions. If pre-authorization is not obtained prior to the sixth visit, authorization will not be retroactive.**

- Dental providers will utilize the ADA (1994) Claim Form to request PA for dental/orthodontic services. The transmission code to be used is "180" in Block 3 of the form. Dentists can utilize the DMAS-351 form when requesting changes or deletions to a PA request, and the DMAS-361 form as the cover sheet for supporting documentation needed in response to a "pend" or if you are sending orthodontic models separate from the PA request. If known, the PA number should be included on the DMAS-361 form.

REMITTANCE ADVICE

The Remittance Advice (RA) has been re-designed to provide additional information to you. Examples of revised RAs are included as Attachment 4 to this memo. The examples provide guidance on how to read the new RAs. In addition, if you bill electronically using the HIPAA-prescribed 837 transaction set, you will receive an electronic RA in the form of the HIPAA-prescribed 835. For the first three months you receive the 835, you will also receive a paper RA. At the end of this period, you will receive an electronic 835 RA only.

CALENDAR OF TRANSITION EVENTS

The following is a calendar illustrating the remittance cycle dates during and after our transition to the new MMIS:

Cycle	Processing Cycle Date	Payment Date
Last cycle on current system	06/13/03	06/20/03
First cycle on new MMIS	06/20/03	07/03/03*
Second cycle on new MMIS	06/27/03	07/11/03
Third cycle on new MMIS	07/04/03	07/18/03
Fourth cycle on new MMIS	07/11/03	07/25/03

Processing and payment cycle dates continue accordingly.

*Electronic Funds Transfer (EFT) payments will also be available on July 3, 2003.

As DMAS makes the transition to the new MMIS, there are some key dates and events of which you need to be aware. Please review the following events carefully as they will impact the time frames for making procedural changes and may impact DMAS' ability to process claims submitted. The events are listed in chronological order.

May 16, 2003 Claims which would normally be pended for additional information will be denied.

May 30, 2003 Deadline for postmark of claims using the current versions of the paper pharmacy and Title XVIII claim forms. Paper claims postmarked after this date must be on the new claim forms, including resubmission of rejected claims. See the "Billing Instructions and Claims Information" section of this memo. Pharmacy providers see separate Medicaid Memo dated April 16, 2003.

EFT enrollments will be temporarily stopped. Enrollments will resume on July 3, 2003.

Deadline for HMOs to submit encounter claims in the current format. Claims submitted after this date must use the 4010 version of the 837, with addenda, i.e., ASC X12N 837.

June 2, 2003 Registration to use the eligibility verification Automated Response System (ARS) begins.

June 6, 2003 All claims in a pend status on June 13, 2003 will be denied in the June 20, 2003 remittance cycle. These claims must be re-submitted as new claims using any applicable revised instructions contained in this memo for claims submitted for processing by the new MMIS. Electronic claims in National Standard Formats may be resubmitted on or after June 16, 2003. Electronic claims in HIPAA-mandated formats may be submitted on or after June 20, 2003. NOTE: If you are an Emergency Department (hospitals and physicians) submitting emergency room claims electronically, **do not** submit these claims after May 16, 2003 if you think they may suspend.

June 11, 2003 Electronically-submitted claims must be submitted by 6:00 a.m. in order to be processed in the June 20, 2003 remittance cycle (payment date).

Deadline for submission of POS pharmacy claims if they are to be included in the June 20, 2003 remittance cycle (payment date).

June 13, 2003 Pre-authorization (PA) requests will not be processed.

All claims processed in the June 13, 2003 remittance cycle will either deny or pay on the remittance dated June 20, 2003. Claims that would ordinarily pend will be denied. These claims must be re-submitted as new claims using any applicable revised instructions contained in this memo for claims submitted for processing by the new MMIS.

June 16, 2003 Production of plastic ID cards for new enrollees begins.

June 20, 2003 HIPAA-compliant transactions will be accepted. National Codes can be used for all HIPAA-compliant transactions. See the DMAS website at http://www.dmas.state.va.us for a crosswalk of Local Codes to National Codes.

July 7, 2003 Production of plastic ID cards for existing enrollees begins.

October 16, 2003 Electronic billers must use HIPAA-compliant transactions for claims submitted on or after this date. Local Codes will not be accepted for claims (electronic or paper) with dates of service on or after this date.

PROVIDER TRAINING

DMAS will be offering training on the new system enhancements to all interested providers. The training will be held on June 5, 2003 and will be performed via teleconference. DMAS will host ten sites statewide in order to make the training accessible to all who have an interest. Registration information will be forthcoming. Continue to watch DMAS' Learning Network at http://www.dmas.state.va.us for updated information.

COPIES OF MANUALS

DMAS will be updating its provider manuals to reflect the new MMIS and HIPAA-related changes. The manuals and manual up-date transmittals will be posted on our website at http://www.dmas.state.va.us as they become available. Please watch for Remittance Advice messages announcing availability of revised manuals.

Provider manuals and transmittals can be viewed on, and printed from, the DMAS website. The transmittals describe the updated materials and manual chapters and pages revised. For a list of updates, click on "up-date transmittals" in the "Provider Manuals" column. If you do not have access to the Internet, or would like a paper copy of a manual, you can order them by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273	Richmond area
1-800-552-8627	All other areas

Please remember that the "HELPLINE" is for provider use only.

Attachments

ATTACHMENT 1

SPECIAL BILLING INSTRUCTIONS FOR STATE AND LOCAL HOSPITAL (SLH) PROVIDERS

- The SLH Program will be changing the method of reimbursement for inpatient medical/surgical hospitalizations effective with claims postmarked after May 30, 2003, regardless of the dates of service. Claims postmarked after May 30, 2003 will be reimbursed the same as Virginia Medicaid, utilizing the All Patient-Diagnosis Related Group (AP-DRG) reimbursement methodology. Inpatient hospitalizations for psychiatric services (principal diagnosis code range of 290-31999) will continue to be reimbursed on a per diem methodology.

- All SLH claims for inpatient hospital services postmarked after May 30, 2003 will pend for manual review excluding those for normal labor and delivery (see below special instructions). The necessary medical records that will need to accompany claims to be reimbursed under the AP-DRG methodology are:

    - History and Physical
    - Admission orders
    - Initial physician progress notes
    - Specialty forms (sterilization, hysterectomy or abortion) if applicable.

- Claims for psychiatric services (principal diagnosis codes with the range of 290 – 31999) will need to include the following medical records:

    - History and Physical
    - Physician orders
    - Physician progress notes
    - Discharge summary
    - Specialty forms (sterilization, hysterectomy or abortion) if applicable

- Claims for normal maternity and newborn inpatient care will not pend for review. These claims are identified by the following parameters:

    - Services for a normal vaginal delivery that contain ICD-9-CM procedure codes within ranges 72.0-72.9, 73.0-73.09, 73.2-73.22, 73.5-73.99, 75.50-75.69 and 75, with a length of stay less than or equal to three days from the date of admission.

    - Services for a cesarean section delivery that contain ICD-9-CM procedure code range 74.1 through 74.99, with a length of stay less than or equal to five days from the date of admission.

- Services for newborns who are in the normal nursery, revenue code 0170 or 0171, with a length of stay less than or equal to five days from the infant's date of birth. Claims for services of a newborn who is in any other nursery setting (i.e., revenue codes 0172, 0173, 0174, or 0179) for any part of the stay will pend for manual review.

Claims submitted outside of the above parameters will pend for review and will need to have the required medical records submitted.

The following is a summary of billing changes for SLH:

- Provider identification numbers will be the same provider numbers that are used for Virginia Medicaid. There will no longer be separate numbers for the SLH Program.

- Providers will use the same national type of bill (locator 4 on UB-92) codes as Virginia Medicaid. These are:

111	Original Inpatient Hospital Invoice
112	Interim Inpatient Hospital Claim Form*
113	Continuing Inpatient
114	Last Inpatient Hospital Claim Invoice*
117	Adjustment Inpatient Hospital Invoice
118	Void Inpatient Hospital Invoice
131	Original Outpatient Invoice
137	Adjustment Outpatient Invoice
138	Void Outpatient Invoice

* The proper use of these codes will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations.

- Interim claims will need to be submitted for hospitalizations that have length of stays greater than 120 days.

- The patient discharge status (UB-92 locator 22) on inpatient hospital claims must be accurate to allow the building of cases necessary for readmission, transfer, and interim claims for accurate DRG reimbursements.

- Ambulatory Surgical Centers (ASC) billing for services provided to an SLH enrollee must include the CPT procedure code (UB-92 locator 44) on the same line as the 0490 revenue code (UB-92 locator 42). Claims will be denied if the CPT code is not included. The CPT code will determine which ASC group rate is to be reimbursed.

- Revenue Codes are expanded to four digits (leading zero, left-justified).

ATTACHMENT 2

GUIDELINES FOR OPTICAL CHARACTER RECOGNITION (OCR)

- Use typewritten characters in 10 or 12 pitch, non-compressed.
- Use standard laser printer fonts - letter quality only
    - Do not mix fonts on the same form
    - Do not use italics or script.
- Use uppercase letters for all alpha characters.
- Change printer cartridge when printed characters begin to fade.
- Do not use special characters such as:
    - dollar signs
    - dashes, slashes, or other symbols.
- Do not rubber band, staple or glue claims together.
- Use black ink.
- Do not use red ink or a derivative of red.
- Print within defined blocks.
- Use the correct P. O. Box number.
- Use one staple for attachments to the claim.
- Write legibly:
    - Return only the information requested
    - Notes, explanations, correspondence, or descriptions should be on full sheets of paper attached behind the claim form.
- Do not include any words or alpha characters in the Enrollee Medicaid ID block.
- Do not submit zero charge claims.
- Enter all information on the same horizontal plane.
- Align all information within the designated field.
- Submit only six line items per claim. (CMS-1500 12/90) Do not squeeze two lines of data onto one line.
- Extraneous data may not be printed, handwritten, or stamped on the form.
- Corrections may be made with white correction tape. Do not use correction fluid. (Cross-outs and write-overs cause recognition problems.)
- Corrections may not be handwritten.

- Do not use highlighters.
- If you use carbon forms, please send only the top, original copy.
- Trim forms carefully only at the perforations. Narrow margins cannot be scanned.
- Noticeable thin paper cannot be used (onion skin).
- The claim should be clean, without smudges or discoloration.
- The claim must measure 8 1/2 x 11 inches.
- Complete all required fields to avoid claims being returned for completion.
- Claims that are not folded are easier to scan. Mail claims in large envelopes. Do not fold claims.
- Do not print slashed zeroes.
- Code information correctly:
    - The Enrollee Medicaid ID must be a 12-digit number
    - The Medicaid Provider ID must at least 7 digits.
- All CMS-1500 claims should be submitted with a valid place of service in Block 24B. The place of service should consist of two numerical digits;
- When applicable, block 32 of the CMS-1500 claim form should indicate the complete physical address of the facility. This information will include the facility's name, street address, city, state and zip code. The word "same" is acceptable in block 32 when the corresponding facility name and address is presented in Block 33 of the CMS-1500 claim form.
- Block 24E of the CMS-1500 claim form should not contain a diagnosis code but the diagnosis indicator 1, 2, 3 or 4, linked to the diagnosis in Block 21.

ATTACHMENT 3

PA SERVICE TYPES

CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC
Mental Health/SA	Outpatient Psych Services	0050	A8	
	Substance Abuse (FAMIS)	0051	AI	
EPSDT Non-State Plan Services	Private Duty Nursing	0090	74	
	Personal Care	0091	42	
	EPSDT DME	0092	12	
	EPSDT Inpatient Psych	0093	A7	
DME	Home	0100	12	
	Nursing Home	0101	12	
	Tech Waiver	0102	12	
REHAB	Intensive Inpt.	0200	AB	
	CORF	0201	AC	
	Special Vent Contract	0202	Non-EDI Request	
	Special Contract (Out of State)	0203	Non-EDI Request	
	Outpt. Rehab	0204	AC	
Medical Support	Organ Transplants	0300	70	
	Out of State Services	0301	1	
	Surgical/Invasive	0302	2	
	Prosthetics	0303	75	
	Muscular/Skeletal Devices	0304	BS	
	Vision	0305	AL	
	Other	0306	1	
Hospital	Inpatient Med/Surg	0400	48	
	Inpatient Psych	0401	48	
Home Health	Home Health	0500	44	
Community MHMR Services	Community MHMR Services	0600	A4	
ECM	Elderly Case Management	0625	3	
TFC CM	Treatment Foster	0700	3	

CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC
	Care Case Mgmt.			
	Non-CSA	**0751**	**A7**	

CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC
Dental Services	**Children, Under 21 years old**	**0800**	**35**	
	Orthodontic, Under 21 years old	**0801**	**38**	
	Adult, Over 21 years old	**0850**	**35**	
Community Based Care (CBC) Waivers	**Elderly & Disabled Waiver (E&D)**	**0900**	**54**	**9**
	IFDDS (Individual and Family Development Disability Services)	**0902**	**54**	**R**
	AIDS Waiver (Respite Care 720 Hrs. Max.)	**0920**	**54**	**E**
	Mental Retardation Waiver (MR)	**0940**	**54**	**Y**
	CDPAS (Consumer Directed Personal Assistant Services)	**0950**	**54**	**Q**
	Tech Waiver (PDN & Respite Care 360 Hrs. Max.)	**0960**	**54**	**A**

ATTACHMENT 4

REMITTANCE ADVICE (RA) EXAMPLES

EXAMPLE 1

SAMPLE

Facility Medical Remittance Advice (FN-O-053)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

XXXXXXXXXXXXXXXXXXXXX **(Provider name)**
XXXXXXXXXXXXXXXXXXXXX **(Provider Address 1)**
XXXXXXXXXXXXXXXXX **(Provider Address 2)**
XXXXXXXXXXXXXXX, XX 99999-9999
(City) **(State)** **(Zip)**

PAGE: 1 of 7
DATE: MM/DD/CCYY
PROVIDER NUMBER 999999999

MESSAGES

REMITTANCE CHECK

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

```
PROGRAM: FNW044                          DEPARTMENT OF MEDICAL ASSISTANCE SERVICES          REPORT:        FN-O-053
PAYEE ID: 999999999 (1)                  First Health Services Corporation - Fiscal Agent (2) REMIT DATE:  MM/DD/CCYY
XXXXXXXXXXXXXXXXXX (3)                             P.O.Box 26228                           PAGE                2
XXXXXXXXXXXXXXXXXX (4)                     Richmond, Virginia 23260-6228           (5)     RA NUMBER:   9999999999
XXXXXXXXXXX, XX 99999-9999
   (6)          (7)  (8)
                                        FACILITY MEDICAL REMITTANCE ADVICE
                              (9)          (10)
BENEFIT PROGRAM CODE  : 01          MEDICAID

_____________________________________________________________________________________________________________
PATIENT NAME           PATIENT ID NUMBER PT CNTL NUMBER          ICN NUMBER          DRG PYMT       PRIM CAR PYMT    TRANSFER AMT
ADMIT DATE               PA NUMBER       FROM/THRU DATE          PRIN DIAG           DRG ASSIGNED   COINSURANCE      TOTAL  CHGS
FINANCIAL RSN CODE       BILL TYPE       COV     NCOV     RED    DRG WEIGHT          CAPITAL PYMT   DEDUCTIBLE       NCOV CHGS
OTHER DIAGS                                                     PRIN PROC           OUTLIER PYMT   CO PAY           PT PAY
OTHER PROCS                                                                         TENT CONTR ADJ COVD BY PROGRAM  NET TENT REIM
LINE ITEM CONTROL NUMBER         EOB CLAIM CODES
_____________________________________________________________________________________________________________
SERVICING PROVIDER : 999999999   (11)
CLAIMS STATUS : APPROVED         (12)

HOSPITAL OUTPATIENT        (13)
 (14)                      (15)          (16)                 (17)              (18)          (19)          (20)
XXXXXXX  XXXXXXXXXX   999999999999    99999999          9999999999999999      0.0000        0.00          0.00
 (21)                      (22)          (23)      (24)       (25)              (26)          (27)          (28)
MM/DD/CCYY             9999999999999  MM/DD/CCYY  MM/DD/CCYY    00000           000          0.00           0.00
 (29)                      (30)       (31)      (32)    (33)    (34)              (35)          (36)          (37)
9999                        999        0000      0001    0000    0.00              0.00          0.00          0.00
 (38)                                                           (39)              (40)          (41)          (42)
99999 99999 9999 9999 99999 9999 9999 99999 9999                9999              0.00          0.00          0.00
 (43)                                                                             (44)          (45)          (46)
XXXXXX XXXXXX XXXXXX XXXXXX XXXXXX XXXXXX XXXXXX                                  0.00          0.00          0.00
 (47)                          (48)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999
                                    (49)                          (50)                  (51)
 DUPLICATE/CONFLICTING ICN - 9999999999999999     RA #  999999999     PAYMENT DATE - MM/DD/CCYY
TPL INFO       : XXXXXXXXXX  (52)
CARRIER NAME   : XXXXXXXXXXXXXXXXXXXXXXXX  (53)
CARRIER ADDR   : XXXXXXXXXX XXXXXXX XXXXXXXXXX XX 99999-9999
                   (54)       (55)       (56)      (57)   (58)

                        (59)      (60)        (61)   (62)     (63)             (64)            (65)             (66)          (67)
                       LINE #   PROCEDURE     REV   UNITS   REV-BILLED-AMT    NON-COV-AMT     REV-ALLWED-AMT CUTBACK-UNITS   CUTBACK-AMT
                         1        XXXXXX      9999   9999      0.00             0.00            0.00           9999           0.00
                         2        XXXXXX      9999   9999      0.00             0.00            0.00           9999           0.00

 - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
```

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-053
REMIT DATE: MM/DD/CCYY
PAGE 3
RA NUMBER: 9999999999

FACILITY MEDICAL REMITTANCE ADVICE

CLAIM TRANSACTION :

	(68) CLAIMS LINES	(69) AMOUNT
ORIGINALS		
APPROVED	9	0.00
PENDED	9	0.00
DENIED	9	0.00
ADJUSTMENTS		
DEBITS	9	0.00
CREDITS	9	0.00CR
CAPITATION PAYMENTS	9	0.00
CASE MANAGEMENT	9	0.00
NET CLAIMS TOTAL:	**(75)** 9	**(76)** 0.00

FINANCIAL TRANSACTION :

	(70) PRIOR BALANCE	(71) CYCLE INCREASE	(72) CYCLE DECREASE	(73) NET CYCLE	(74) CURRENT BALANCE
NEG BALANCE	0.00	0.00	0.00	0.00	0.00
VOID CHECKS					
VOID	0.00	0.00	0.00	0.00	0.00CR
ADD-PAYS	0.00	0.00	0.00	0.00	0.00

NET CLAIMS	(+)	0.00	**(77)**
ADD-PAYS	(+)	0.00	**(78)**
*NEGATIVE BALANCE	(-)	0.00	**(79)**
PROGRAM TOTAL:		0.00	**(80)**

*NEGATIVE BALANCE IS THE AMOUNT DECREASED DURING THE REMIT CYCLE

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-053
REMIT DATE: MM/DD/CCYY
PAGE 4
RA NUMBER: 9999999999

FACILITY MEDICAL REMITTANCE ADVICE

(81) EOB CODE	(82) EOB DESCRIPTION	(83) ADJ/RSN	(84) REMARKS/NCPDP/STATUS
9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXXXX
9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXXXX

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-053
REMIT DATE: MM/DD/CCYY
PAGE 5
RA NUMBER: 9999999999

FACILITY MEDICAL REMITTANCE ADVICE

(85)

ADJ REASON	DESCRIPTION
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-053
REMIT DATE: MM/DD/CCYY
PAGE 6
RA NUMBER: 9999999999

FACILITY MEDICAL REMITTANCE ADVICE

(86)

REMARKS/NCPDP/STATUS	DESCRIPTION
XXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SAMPLE **Facility Medical Remittance Advice (FN-O-053)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-053
REMIT DATE: MM/DD/CCYY
PAGE 7
RA NUMBER: 9999999999

FACILITY MEDICAL REMITTANCE ADVICE

REMITTANCE SUMMARY

PROGRAM TOTALS	AMOUNTS	
MEDICAID	$0.00	(87)
REMITTANCE TOTAL:	$0.00	(88)
LIENS	$0.00	(89)
PROVIDER TOTAL:	$0.00	(90)

YEAR-TO-DATE TOTAL PAID (1099) $0.00 (91)

CHECK NUMBER (92) 999999999 WAS ISSUED FOR (93) $0.00 WITH THIS REMITTANCE

PRIOR LIEN BALANCE $0.00 (94) LIEN CYCLE DECREASE $0.00 (95) LIEN CURR BALANCE $0.00 (96)

THIS REMITTANCE SCHEDULE WILL BE DEEMED CORRECT,
IF ERRORS ARE NOT REPORTED WITHIN 20 DAYS TO:
DEPT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD ST. SUITE 1300
Richmond, VA 23219

*NEGATIVE BALANCE IS THE AMOUNT DECREASED DURING THE REMIT CYCLE

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
1	PAYEE ID	Remittance Payee Identification Number	9588	Claims Billing Provider Identification Number
2	REMIT DATE	Remittance Payment Date	9578	Generated based on Remittance Cycle
3	PAYEE NAME	Remittance Payee Name	9589	
4	PAYEE ADDRESS	Remittance Payee Address Line	9590	
5	RA NUMBER	Remittance Advice Number	9580	System generated and incremented by one.
6	PAYEE CITY	Remittance Payee City	9592	
7	PAYEE STATE	Remittance Payee State	9593	
8	PAYEE ZIP CODE	Remittance Payee Zip Code	9594	
9	BENEFIT PROGRAM CODE	Benefit Definition Plan Program Code	3551	
10	BENEFIT PROGRAM DESCRIPTION	Enrollee Benefit Plan Exception Code Description	3076	
11	SERVICING PROVIDER	Provider Identification Number	4002	
12	CLAIMS STATUS	Claim Status	2039	
13	CLAIM TYPE	Claim Type	2002	
14	PATIENT NAME	Enrollee Full Name	3003	
15	PATIENT ID NUMBER	Enrollee Identification Number	3001	
16	PT CNTL NUMBER	Claim Patient Account Number	2031	
17	ICN NUMBER	Claim Request ICN	2001	
18	DRG PYMT	DRG Payment Amount	2547	
19	PRIM CAR PYMT	Claim Third Party Payment	2018	If pended, claim amount set to zero.
20	TRANSFER AMOUNT	Claim DRG Per Diem Amount	2594	Transfer amount equals DRG Per Diem when DRG Payment Type = 'T'.

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				If pended, claim amount set to zero.
21	ADMIT DATE	Claim Admission Date	2105	
22	PA NUMBER	Claim Prior Authorization Control Number	2024	
23	FROM DATE	Claim Service From Date	2010	
24	THRU DATE	Claim Service Thru Date	2011	
25	PRIN DIAG	Diagnosis Code	5301	
26	DRG ASSIGNED	DRG (Diagnosis Related Group) Code	5353	
27	COINSURANCE	Claim Calculated Co-Insurance	2545	
28	TOTAL CHGS	Claim Billed Charge	2016	
29	FINANCIAL RSN CODE	Claim Adjustment Reason	2033	
30	BILL TYPE	Claim Facility Bill Type	2102	
31	COV	Claim Covered Days	2108	
32	NCOV	Claim Non-Covered Days	2109	
33	RED	Claim Reduced Payment Days	2358	
34	DRG WEIGHT	DRG Relative Weight	5354	
35	CAPITAL PYMT	Provider Rate	4255	
36	DEDUCTIBLE	Claim Title XVIII Deductible Amount	2251	If pended, claim amount set to zero.
37	NCOV CHGS	Claim Non-Covered Amount	2139	If pended, claim amount set to zero.
38	OTHER DIAGS	Diagnosis Code	5301	
39	PRIN PROC	Procedure Code	5002	
40	OUTLIER PYMT	MARS DRG Outlier Payment Amount	6827	If pended, claim amount set to zero.
41	CO-PAY	Claim Medicaid Co-Payment	2022	If pended, claim amount set to zero.
42	PT PAY	Claim Patient Pay Amount	2083	If pended, claim amount set to zero.
43	OTHER PROCS	Procedure Code	5002	

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
44	TENT CONTR ADJ		Calculated	Total Charges minus Net Tent Reimb If pended, claim amount is set to zero
45	COV'D BY PROGRAM	Claim Allowed Amount	2073	If pended, claim amount is set to zero.
46	NET TENT REIM	Claim Payment Amount	2023	If pended, claim amount set to zero.
47	LINE ITEM CONTROL NUMBER	Claim EDI Line Item Control Number	2012	
48	EOB CLAIM CODES	Error Text Error Code	5501	
49	DUPLICATE/CONFLICTING ICN		N/A	
50	RA #	Remittance Advice Number	9580	
51	PAYMENT DATE	Remittance Payment Date	9578	
52	TPL INFO	TPL Policy Number	3658	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
53	CARRIER NAME	TPL Carrier Name	3673	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
54	CARRIER ADDR 1	TPL Carrier Additional Address Name	3674	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
55	CARRIER ADDR	TPL Carrier Address Line	3675	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
56	CARRIER ADDR	TPL Carrier City Name	3676	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
57	CARRIER ADDR	TPL Carrier State Code	3677	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Claim Type Modifier is set to '4' (Voided Claim).
58	CARRIER ADDR	TPL Carrier ZIP Code	3678	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
59	LINE #	Claims Facility Revenue Line Number	2445	This done for Inpatient and Outpatient Claims
60	PROCEDURE	Procedure Code	5002	This done for Inpatient and Outpatient Claims
61	REV	Claim Revenue Code	2122	This done for Inpatient and Outpatient Claims
62	UNITS	Claim Number of Units/Visits/Studies	2009	This done for Inpatient and Outpatient Claims
63	REV-BILLED-AMT	Claim Revenue Amount	2124	This done for Inpatient and Outpatient Claims If pended, claim amount set to zero.
64	NON-COV-AMT	Claim Non-Covered Amount	2139	This done for Inpatient and Outpatient Claims If pended, claim amount set to zero.
65	REV-ALLWED-AMT	Claim Revenue Allowed Amt	2991	This done for Inpatient and Outpatient Claims If pended, claim amount set to zero.
66	CUTBACK-UNITS	Claim Cutback Days/Units	2065	This done for Inpatient and Outpatient Claims
67	CUTBACK-AMT	Claim Cutback Amount	2066	This done for Inpatient and Outpatient Claims

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
68	CLAIMS LINES		Calculated	If pended, claim amount set to zero. ORGINALS Approved: The total number of lines for all claims where Claim Disposition equal to '1' , Claim Status equal to '1' and Claim Types equal to 01, 02, 03 and 10. Pended: The total number of lines for all claims where Claim Disposition equal to 1, 2, 3 or 4 , Claim Status equal to '2' and Claim Types equal to 01, 02, 03, and 10 Denied: The total number of lines for all claims where Claim Disposition equal to 1,2, 3, or 4 Claim Status equal to 3 or 6 and Claim Types equal to 01, 02, 03, and 10 ADJUSTMENTS: Debits: The total number of lines for all claims where Claims Disposition equal to 2, Claim Status equal to 1 and Claims Types equal to 01, 02, 03 or 10 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) Credits: The total number of lines for all claims where Claims Disposition equal to 3 or 4, Claim Status equal to 1 and Claims Types equal to 01, 02, 03 or 10 and Financial

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
69	AMOUNT		Calculated	Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) CAPITATION PAYMENTS This field will be equal to zero. Only populated for Professional Remittance Advice (FN-O-054) CASE MANAGEMENT This field will be equal to zero. Only populated for Professional Remittance Advice (FN-O-054) ORIGINALS Approved: The total amount paid for all claims where Claim Disposition equal to '1' , Claim Status equal to '1' and Claim Types equal to 01, 02, 03, 04, and 10. Pended: No calculation Denied: No calculation ADJUSTMENTS: Debits: The total amount paid for all claims where Claims Disposition equal to 2, Claim Status equal to 1 and Claims Types equal to 01, 02, 03, 04, 10, 15, 16 or 17 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) Credits:

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				The total amount paid for all claims where Claims Disposition equal to 3 or 4, Claim Status equal to 1 and Claims Types equal to 01, 02, 03, 04, 10, 15, 16 or 17 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) CAPITATION PAYMENTS The total amount paid for all claims where Claim Disposition equal to 1, Claims Status equal to 1 and Claim Type equal to 15 CASE MANAGEMENT The total amount paid for all claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Types equal to 16 and 17
70	PRIOR BALANCE		Calculated	Neg Balance Prior Balance = Provider Negative Balance Previous
71	CYCLE INCREASE		Calculated	Neg Balance Cycle Increase = Claim Payment Amount for RA Detail Lines with Gone Negative Indicator = 'Y' for current cycle
72	CYCLE DECREASE		Calculated	Neg Bal Cycle Decrease = Total Negative Balance Amount Recoup ** Total Negative Balance Recoup = Total Negative Balance Recoup + Negative Balance Amount Recoup
73	NET CYCLE		Calculated	Negative Balance Net Cycle = Negative Balance Cycle Increase + Negative Balance Cycle Decrease
74	CURRENT BALANCE		Calculated	Negative Balance Current Amount =

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Provider's Previous Negative Balance + Negative Balance Net Cycle Void Checks Current Amount = Void Checks Amount + Void Checks Net Cycle Add-Pay Current Amount = Add-pay + Add-Pay Net Cycle Recoupment Current Amount = Recoupment Amount + Recoupment Net Cycle Lien Current Amount = Lien Amount + Lien Net Cycle
75	NET CLAIMS LINES		Calculated	Net Claim Lines = Claim Transactions Original Lines + Claim Transactions Adjustments + Capitation Payment Lines + Case Management Lines
76	NET CLAIMS AMOUNT		Calculated	Net Claim Amount = Claim Transactions Original Amount + Claim Transactions Adjustment Amount + Capitation Payments Amount + Case Management Amount
77	NET CLAIMS		Calculated	Net Claims Total Amount
78	ADD-PAYS		Calculated	Add-Pays Current Amount
79	NEGATIVE BALANCE		Calculated	Negative Balance Current Amount
80	PROGRAM TOTAL -- (REMITTANCE PROGRAM SUMMARY PAGE)		Calculated	Program Total = Net Claims Total Amount (DB) + Add-Pay Net Current Amount (DB) + Recoupments Current Amount (CR) + Negative Balance Current Amount (CR)
81	EOB CODE	Error Text Error Code	5501	If RA Print Indicator is equal to 'N' then use default message ('Under DMAS Review') on Remittance Advice
82	EOB DESCRIPTION	Error Text Long Description	5514	
83	ADJ/RSN	HIPAA Adjustment Reason Code	5580	

FIELD DEFINITIONS Facility Medical Remittance Advice (FN-O-053)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
84	REMARKS/NCPDP/STATUS	Claim Response Code	5540	
85	ADJ REASON DESCRIPTION	HIPAA Adjustment Reason Short Description	5586	
86	REMARKS/NCPDP/STATUS DESCRIPTION	Claim Response Short Description	5549	
87	PROGRAM TOTALS -- (REMITTANCE SUMMARY PAGE		Calculated	Program Totals = Program Totals + Program Total (Total Amount for all programs for current cycle)
88	REMITTANCE TOTAL -- (REMITTANCE SUMMARY PAGE)		Calculated	Remittance Total = Sum of Program Totals
89	LIENS -- (REMITTANCE SUMMARY PAGE)		Calculated	Total Lien Amount for current cycle
90	PROVIDER TOTAL		Calculated	Provider Total = Remittance Total - Liens
91	YEAR-TO-DATE TOTAL PAID	Provider Current Year-to-Date Total 1099 Amount	4155	Year To Date Total Paid = Year To Date Total Paid + Remittance Total Amount
92	CHECK NUMBER	Remittance Check Number	9576	
93	CHECK AMOUNT	Remittance Check Amount	9577	
94	PRIOR LIEN BALANCE		Calculated	
95	LIEN CYCLE DECREASE		Calculated	
96	LIEN CURR BALANCE		Calculated	

EXAMPLE 2

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

XXXXXXXXXXXXXXXXXXXXXX **(Provider name)**
XXXXXXXXXXXXXXXXXXXXXX **(Provider Address 1)**
XXXXXXXXXXXXXXXXX **(Provider Address 2)**
XXXXXXXXXXXXXXX, XX 99999-9999
(City) **(State)** **(Zip)**

PAGE: 1 of 7
DATE: MM/DD/CCYY
PROVIDER NUMBER 999999999

MESSAGES

REMITTANCE CHECK

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

```
PROGRAM: FNW044                          DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT:        FN-O-054
PAYEE ID: 999999999 (1)                  First Health Services Corporation - Fiscal Agent          (2) REMIT DATE:  MM/DD/CCYY
XXXXXXXXXXXXXXXXXXXXX (3)                          P.O.Box 26228                                      PAGE                2
XXXXXXXXXXXXXXXXXXXXX (4)                  Richmond, Virginia 23260-6228                       (5) RA NUMBER:   9999999999
XXXXXXXXXX, XX 99999-9999
   (6)    (7)    (8)                          PROFESSIONAL MEDICAL REMITTANCE ADVICE
  (9)          (10)
BENEFIT PROGRAM CODE  : 01        MEDICAID
_____________________________________________________________________________________________________________________
PATIENT NAME                  PATIENT ID NO   PT ACCT/RX NO          ICN NUMBER          FROM/THRU DATE      PROC/NDC #     MOD
BILLED AMT NON-COV-AMT        COVERED BY PGM  DEDUCT/COINS           CO/PT PAY           PRIM CAR PAY        TOOTH#/SURFACE
  UNITS    PA NUMBER          FINANCIAL RSN CODE                                                              TOTAL PAYMENT
LINE ITEM CONTROL NUMBER      EOB CLAIM CODES
_____________________________________________________________________________________________________________________
SERVICING PROVIDER : 999999999  (11)
CLAIMS STATUS : APPROVED        (12)

XXXXXXXXXXXXXX  (13)
   (14)                          (15)          (16)                (17)             (18)        (19)    (20)  (21)      (22)
XXXXXXXXXXXXXX  XXXXXXXXXXXX  999999999999     99-99          9999999999999999    MM/DD/CCYY MM/DD/CCYY XXXXX 9999      XX
  (23)     (24)                 (25)          (26)  (27)      (28)    (29)             (30)              (31)  (32)
  0.00     0.00                 0.00          0.00 / 0.00     0.00    0.00             0.00              XX     X
  (33)       (34)               (35)                                                                      (36)
  9999     9999999999999        9999                                                                    0.00 CR

TPL  INFO    : XXXXXXXXX (37)       -
CARRIER NAME : XXXXXXXXX/XXXXXXXXXXXXX   (38/39)
CARRIER ADDR : XXXXXXXXXXXXX XXXXXXXXXX XX 99999-9999
 -               (40)         (41)      (42)  (43)
 -   - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
XXXXXXXXXXXXXX  XXXXXXXXXXXX  999999999999     99-99          9999999999999999    MM/DD/CCYY MM/DD/CCYY XXXXX 9999      XX
   0.00     0.00                 0.00          0.00 / 0.00     0.00    0.00             0.00              XX     X
   9999     9999999999999        9999                                                                    0.00 CR

  (44)          (45)          (46)          (47)         (48)
 LINE #         NDC           QTY         ALLOWED AMT    EOB
   1        99999999999       0.00000       0.00         9999
   2        99999999999       0.00000       0.00         9999
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
```

SAMPLE

Professional Medical Remittance Advice (FN-O-054)

```
PROGRAM: FNW044                          DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT:        FN-O-054
PAYEE ID: 999999999                    First Health Services Corporation - Fiscal Agent               REMIT DATE:  MM/DD/CCYY
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      P.O.Box 26228                                  PAGE                 3
XXXXXXXXXXXXXXXXX                          Richmond, Virginia 23260-6228                            RA NUMBER:   9999999999
XXXXXXXXXX, XX 99999-9999

                                        PROFESSIONAL MEDICAL REMITTANCE ADVICE

CLAIM TRANSACTION :                                    FINANCIAL TRANSACTION :    (51)       (52)       (53)       (54)       (55)
                    CLAIMS LINES    AMOUNT                                          PRIOR      CYCLE      CYCLE      NET        CURRENT
ORIGINALS                (49)          (50)                                       BALANCE    INCREASE   DECREASE   CYCLE      BALANCE
      APPROVED            9            0.00
      PENDED              9            0.00    NEG BALANCE                        0.00       0.00CR     0.00       0.00       0.00CR
      DENIED              9            0.00
ADJUSTMENTS                                      VOID CHECKS
      DEBITS              9            0.00          VOID                         0.00       0.00       0.00       0.00       0.00CR
      CREDITS             9            0.00CR
CAPITATION PAYMENTS       9            0.00
CASE MANAGEMENT           9            0.00    ADD-PAYS                           0.00       0.00       0.00       0.00       0.00
                    ___________    ___________
NET CLAIMS TOTAL:         9            0.00CR
                         (56)          (57)
                      NET CLAIMS       (+)              0.00CR     (58)
                      ADD-PAYS         (+)              0.00       (59)
                     *NEGATIVE BALANCE (-)              0.00       (60)
                                                    ==========
                      PROGRAM TOTAL:                   0.00CR     (61)
-
-
-
-     *NEGATIVE BALANCE IS THE AMOUNT DECREASED DURING THE REMIT CYCLE
```

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-054
REMIT DATE: MM/DD/CCYY
PAGE 4
RA NUMBER: 9999999999

PROFESSIONAL MEDICAL REMITTANCE ADVICE

(62) EOB CODE	(63) EOB DESCRIPTION	(64) ADJ REASON	(65) REMARKS/NCPDP/STATUS
9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXX
9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXX

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

```
PROGRAM: FNW044                          DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT:        FN-O-054
PAYEE ID: 999999999                    First Health Services Corporation - Fiscal Agent               REMIT DATE:  MM/DD/CCYY
XXXXXXXXXXXXXXXXXX                                  P.O.Box 26228                                     PAGE                5
XXXXXXXXXXXXXXXXXX                            Richmond, Virginia 23260-6228                           RA NUMBER:   9999999999
XXXXXXXXXX, XX 99999-9999

                                                PROFESSIONAL MEDICAL REMITTANCE ADVICE
                                                          (66)
                ADJ REASON                DESCRIPTION

                 XXXXX                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXXX                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-054
REMIT DATE: MM/DD/CCYY
PAGE 6
RA NUMBER: 9999999999

PROFESSIONAL MEDICAL REMITTANCE ADVICE

(67)

REMARKS/NCPDP/STATUS	DESCRIPTION
XXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SAMPLE **Professional Medical Remittance Advice (FN-O-054)**

PROGRAM: FNW044
PAYEE ID: 999999999
XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXX
XXXXXXXXXX, XX 99999-9999

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
First Health Services Corporation - Fiscal Agent
P.O.Box 26228
Richmond, Virginia 23260-6228

REPORT: FN-O-054
REMIT DATE: MM/DD/CCYY
PAGE 7
RA NUMBER: 9999999999

PROFESSIONAL MEDICAL REMITTANCE ADVICE

REMITTANCE SUMMARY

PROGRAM TOTALS	AMOUNTS	
MEDICAID	$0.00	(68)
REMITTANCE TOTAL:	$0.00	(69)
LIENS	$0.00	(70)
PROVIDER TOTAL:	$0.00	(71)

YEAR-TO-DATE TOTAL PAID (1099) $0.00 (72)

CHECK NUMBER (73) 999999999 WAS ISSUED FOR (74) $0.00 WITH THIS REMITTANCE

PRIOR LIEN BALANCE $0.00 (75) LIEN CYCLE DECREASE $0.00 (76) LIEN CURR BALANCE $0.00 (77)

THIS REMITTANCE SCHEDULE WILL BE DEEMED CORRECT,
IF ERRORS ARE NOT REPORTED WITHIN 20 DAYS TO:
DEPT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD ST. SUITE 1300
Richmond, VA 23219

*NEGATIVE BALANCE IS THE AMOUNT DECREASED DURING THE REMIT CYCLE

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
1	PAYEE ID	Remittance Payee Identification Number	9588	Claim Billing Provider Identification Number
2	REMIT DATE	Remittance Payment Date	9578	Generated based on Remittance Cycle
3	PAYEE NAME	Remittance Payee Name	9589	
4	PAYEE ADDRESS	Remittance Payee Address Line	9590	
5	REMITTANCE NUMBER	Remittance Advice Number	9580	System generated and incremented by one
6	PAYEE CITY	Remittance Payee City	9592	
7	PAYEE STATE	Remittance Payee State	9593	
8	PAYEE ZIP CODE	Remittance Payee Zip Code	9594	
9	BENEFIT PROGRAM CODE	Benefit Definition Plan Program Code	3551	
10	BENEFIT PROGRAM DESCRIPTION	Enrollee Benefit Plan Exception Code Description	3076	
11	SERVICING PROVIDER	Provider Identification Number	4002	
12	CLAIMS STATUS	Claim Status	2039	
13	CLAIM TYPE	Claim Type	2002	
14	PATIENT NAME	Enrollee Full Name	3003	
15	PATIENT ID NO	Enrollee Identification Number	3001	
16	PT ACCT/RX NO	Claim Patient Account Number	2031	
17	ICN NUMBER	Claim Request ICN	2001	
18	FROM DATE	Claim Service From Date	2010	
19	THRU DATE	Claim Service Thru Date	2011	
20	PROC	Procedure Code	5002	
21	NDC #	NDC Drug Sequence Number	2450	If Compound Drug claim then 'COMPOUND' is moved to this field
22	MOD	Claims Procedure Code Modifier	2171	

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
23	BILLED AMT	Claim Billed Charge	2016	
24	NON-COV-AMT	Claim Non-Covered Amount	2139	If pended, claim amount set to zero.
25	COVERED BY PGM	Claim Allowed Amount	2073	If pended, claim amount set to zero.
26	DEDUCT	Claim Title XVIII Deductible Amount	2251	If pended, claim amount set to zero.
27	COINS	Claim Title XVIII Coinsurance Amount	2252	If pended, claim amount set to zero.
28	CO PAY	Claim Medicaid Co-Payment	2022	If pended, claim amount set to zero.
29	PT PAY	Claim Patient Pay Amount	2083	If pended, claim amount set to zero.
30	PRIM CAR PAY	Claim Third Party Payment	2018	If pended, claim amount set to zero.
31	TOOTH #	Claim Dental Tooth Code	2200	
32	SURFACE	Claim Dental Surface Codes	2201	
33	UNITS	Claim Number of Units/Visits/Studies	2009	Units = Units Billed - Cutback
34	PA NUMBER	Claim Prior Authorization Control Number	2024	
35	FINANCIAL RSN CODE	Claim Adjustment Reason	2033	
36	TOTAL PAYMENT	Claim Payment Amount	2023	If pended, claim amount set to zero.
37	TPL INFO	TPL Policy Number	3658	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
38	CARRIER NAME	TPL Carrier Name	3673	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
39	CARRIER NAME	TPL Carrier Additional Address Name	3674	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
40	CARRIER ADDR	TPL Carrier Address Line	3675	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Claim).
41	CARRIER ADDR	TPL Carrier City Name	3676	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
42	CARRIER ADDR	TPL Carrier State Code	3677	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
43	CARRIER ADDR	TPL Carrier ZIP Code	3678	This field is populated when the Claims TPL Pay Chase Flag is set to 'Y' and the Claim Type Modifier is set to '4' (Voided Claim).
44	LINE #	NDC Drug Sequence Number	2450	This field is populate for Compound Drug claims
45	NDC	Drug Code (NDC)	5200	This field is populate for Compound Drug claims
46	QTY	Claims Pharmacy Metric/Dec/Qty	2248	This field is populate for Compound Drug claims
47	ALLOWED AMOUNT	Pharmacy Ingredient Cost	2223	This field is populate for Compound Drug claims
48	EOB CODES	Error Text Error Code	5501	
49	CLAIM LINES		Calculated	ORIGINALS Approved: Total number of claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, or 13 Pended: Total number of claims where Claim Disposition equal to 1, 2, 3 or 4, Claim Status equal to 2 and Claim Types equal to

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				05, 06, 08, 09, 11 or 13 Denied: Total number of claims where Claim Disposition equal to 1, 2, 3 or 4, Claim Status equal to 3 or 6 and Claim Types equal to 05, 06, 08, 09, 11 or 13 ADJUSTMENTS Debit: Total number of claims where Claim Disposition equal to 2, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, 13, 15, 16 or 17 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) Credit: Total number of claims where Claim Disposition equal to 3 or 4, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, 13, 15, 17 or 18 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) CAPITATION PAYMENTS Total number of claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Type equal to 15 CASE MANAGEMENT Total number of claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Type equal to 16 or 17
50	CLAIM AMOUNT		Calculated	ORIGINALS

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Approved: Total amount paid for all claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, or 13 Pended: No calculation Denied: No calculation ADJUSTMENTS Debit: Total amount paid for all claims where Claim Disposition equal to 2, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, 13, 15, 16 or 17 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) Credit: Total amount paid for all claims where Claim Disposition equal to 3 or 4, Claim Status equal to 1 and Claim Types equal to 05, 06, 08, 09, 11, 13, 15, 16 or 17 and Financial Adjustments Reason Codes are not for Cash Receipts and Stop Payment (Voided Checks) CAPITATION PAYMENTS Total amount paid for all claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Type equal to 15 CASE MANAGEMENT

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Total amount paid for all claims where Claim Disposition equal to 1, Claim Status equal to 1 and Claim Type equal to 16 or 17
51	PRIOR BALANCE		Calculated	Neg Balance Prior Balance = Provider Negative Balance Previous
52	CYCLE INCREASE		Calculated	Neg Balance Cycle Increase = Claim Amount for RA Detail Lines with Gone Negative Indicator equal to 'Y' for current cycle
53	CYCLE DECREASE		Calculated	Neg Bal Cycle Decrease = Total Negative Balance Amount Recoup (Total Negative Balance Recoup = Total Negative Balance Recoup + Negative Balance Recoup)
54	NET CYCLE		Calculated	Negative Balance Net Cycle = Negative Balance Cycle Increase + Negative Balance Cycle Decrease
55	CURRENT BALANCE		Calculated	Negative Balance Current Amount = Provider's Prior Negative Balance + Negative Balance Net Cycle Void Checks Current Amount = Sum of Void Check Financial Transactions Add-Pay Current Amount = Sum of Add-Pay transactions Recoupment Current Amount = Sum of Recoupment transactions
56	NET CLAIM LINES		Calculated	Net Claim Lines = Claim Transactions Original Lines + Claim Transaction Adjustment Lines + Capitation Payment Lines + Case Management Payment Lines
57	NET CLAIMS AMOUNT		Calculated	Net Claim Amount = Claims Transactions Original Amount + Claims Transactions

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
				Adjustment Amount + Capitation Payments Amount + Case Management Amount
58	NET CLAIMS		Calculated	Net Claims = Net Claims Total Amount
59	ADD-PAYS		Calculated	Add-Pays = Add-Pays Current Amount
60	NEGATIVE BALANCE		Calculated	Negative Balance = Negative Balance Current Amount
61	PROGRAM TOTALS (REMITTANCE PROGRAM SUMMARY PAGE)		Calculated	Program Total = Net Claims Total Amount (DB) + Add-Pay Net Current Amount (DB) + Recoupments (CR) Current Amount + Negative Balance Current Amount (CR)
62	EOB CODE	Error Text Error Code	5501	If RA Print Indicator is equal to 'N' then use default message ('Under DMAS Review') on Remittance Advice
63	EOB DESCRIPTION	Error Text Long Description	5514	
64	ADJ REASON	HIPAA Adjustment Reason Code	5580	
65	REMARKS/NCPDP/STATUS	Claim Response Code	5540	
66	ADJ REASON DESCRIPTION	HIPAA Adjustment Reason Short Description	5586	
67	REMARKS/NCPDP/STATUS DESCRIPTION	Claim Response Short Description	5549	
68	PROGRAM TOTALS -- (REMITTANCE SUMMARY PAGE)		Calculated	Remittance Total = Remittance + Program Total (Total Amount for all programs for current cycle)
69	REMITTANCE TOTAL -- (REMITTANCE SUMMARY PAGE)		Calculated	Remittance Total = Sum of Program Totals
70	LIENS (REMITTANCE SUMMARY PAGE)		Calculated	Total Lien Amount for current cycle
71	PROVIDER TOTAL		Calculated	Provider Total = Remittance Total - Liens
72	YEAR-TO-DATE TOTAL PAID	Provider Current Year-to-Date Total	4155	

FIELD DEFINITIONS Professional Medical Remittance Advice (FN-O-054)

Field No.	Field Name	Data Element Name	VaMMIS DE No.	Source/Calculations
		1099 Amount		
73	CHECK NUMBER	Remittance Check Number	9576	
74	CHECK AMOUNT	Remittance Check Amount	9577	
75	PRIOR LIEN BALANCE		Calculated	
76	LIEN CYCLE DECREASE		Calculated	
77	LIEN CURR BALANCE		Calculated	

ATTACHMENT 5
FORMS

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	**MM**	**DD**	**CCYY**	**Sequence Number (5 digits)**
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First Name:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)** _____

COMMENTS: _____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us . Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

CPR288 (1)
PROVIDER NO: 999999999

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
TURNAROUND DOCUMENT
(2.1) DENTAL CLAIM

REPORT NO: CP-O-418-01
DATE: MM/DD/CCYY
PAGE: ZZ,ZZ9

(2)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ATTN:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (2.2)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (2.3)
XXXXXXXXXXXX, XX 99999-9999
(2.4) (2.5) (2.6)

ICN: XXXXXXXXXXXXXXXX
(3)

(4)
ENROLLEE NO: 999-999999-99-9
(5) (6) (7)
ENROLLEE NAME: XXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXX
PATIENT ACCOUNT NO: XXXXXXXXXXXXXXXXXXXX (8)
DATE OF SERVICE: MM/DD/CCYY - MM/DD/CCYY
(9) (10)

THE CLAIM(S) IDENTIFIED ABOVE CONTAIN(S) MISSING/INVALID INFORMATION. MAKE THE CORRECTIONS TO THE MISSING/INVALID DATA SHOWN BELOW ON THE LINE BESIDE THE INFORMATION TO BE CORRECTED. IF ANY OTHER DATA IS INCORRECT, ANOTHER CLAIM WILL HAVE TO BE SUBMITTED. THIS CORRECTED COPY MUST BE RECEIVED BEFORE 05/08/2001
(11)

(12) CLAIM LINE NO	(13) OCCUR	(14) ERROR	(15) MESSAGE	(16) INVALID DATA	(17) CORRECTED DATA
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________
99	9999	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	___________________________

I HEREBY AMEND/CORRECT, AS INDICATED ABOVE, THE MEDICAID CLAIM(S) IDENTIFIED ABOVE ON THIS SHEET AND I REQUEST THAT REPROCESSING OF THE SAID CLAIM(S) BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM(S) IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE(SE) CLAIM(S) FOR SERVICE(S) AND INFORMATION IS/ARE TRUE AND CORRECT. I UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS ON THE ORIGINAL CLAIM(S), FRONT AND REVERSE SIDES, AND THE CURRENT MEDICAID PROVIDER MANUAL APPLY TO THE AMENDMENTS/CORRECTIONS AS IF INCORPORATED HEREIN. I UNDERSTAND THAT PAYMENT OF THE(SE) CLAIM(S) WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PROVIDER SIGNATURE: ______________________________ DATE: __________

PLEASE RETURN TO: FIRST HEALTH SERVICES
P.O. BOX 26228
RICHMOND, VA 23260

(18)

MM/DD/CCYY

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

INSTRUCTIONS: Complete this form on the initial home visit for all BabyCare recipients. *Items in italics apply to pregnant women only*. **Items in bold type apply only to infants.** Items in normal type apply to both women and infants.. **See explanation of codes on reverse of form.

1. Last Name _____ 2. First Name _____ 3. MI _____
For Infant, name of mother/guardian _____
4. Street Address _____ 5. City _____ 6. State_____ 7. Zip _____
8. Recipient's Medicaid ID # __ __ __ __ __ __ __ __ __ __ __ __ 9. Birthdate __ __ - __ __ - __ __ __ __

**10. Occupation (circle one) 0 1 2 9 **11. Marital Status (circle one) 0 1 9 **12. Education Level (circle one) 0 1 2 9
13. # of Live Births __ __ *14. Abortions __ __* *15. Miscarriages __ __* *16. Stillbirths __ __*
17. EDC __ __ - __ __ - __ __ __ __ *18. Wks gestation when prenatal care began __ __*

19. Provider Name _____ 20. Provider # __ __ __ __ __ __ __ __ __ __ __ 21.Visit Date __ __ - __ __ - __ __ __ __

Psychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home	___	____	28. Insufficient funds for food	___	____	**34. Caregiver handicap**	___	___
23. Poor support system	___	____	29. Transportation need	___	____	**35. Maternal absence**	___	___
24. Poorly motivated	___	____	30. Neglect/Abuse	___	____	**36. Protective services**	___	___
25. Religious/ethnic factors affecting pregnancy	___	____	31. Childcare needs/poor parenting knowledge/pregnancy infor.	___	____	**37. Poor emotional bonding**	___	___
26. Housing needs	___	____	32. Multiple medical providers	___	____			
27. Family has urgent health needs	___	____	33. Mental retardation/ emotional problems	___	____			

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation	___	___	42. Genetic Disorder	___	___	**45. Infant chronic illness**	___	___
39. Prior preterm <5 1/2 lb.	___	___	43. Previous fetal/infant death or infant morbidity	___	___	**46 Developmental delay**	___	___
40. Advanced maternal age >35	___	___				**47 Infant apnea**	___	___
41. Medical condition affecting pregnancy/infant	___	___	44. Previous poor pregnancy experience - medical	___	___	**48. Birth weight<3lbs 14 oz**	___	___

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt.	___	___	54. Poor basic diet info	___	___	59. Anemia	___	___
50. Prepregnancy underwgt.	___	___	55. Special diet/formula prescribed	___	___	**60. Inadequate sucking**	___	___
51. Excessive Nausea/Vomiting	___	___	56. Medical Condition affects diet	___	___	**61. Breast feeding problems**	___	___
52. Excessive wgt. gain	___	___	57. Inadequate cooking facility	___	___	**62. Poor use of**		
53. Inadequate wgt. gain	___	___	58. Mother age 18 or younger	___	___	**special formula**	___	___

Substance Abuse Usage At Current Time

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
63. Alcohol	____	____	*66. Marijuana/hashish*	____	____	*69. Inhalants*	____	____
64. Cocaine/crack	____	____	*67. Sedatives/tranquilizers*	____	____	*70. Tobacco/cig*	____	____
65. Narcotics/heroin/codeine	____	____	*68. Amphetamines/diet pill*	____	____	*71. Other*	____	____

Substance Abuse Usage Prior To Start Of Pregnancy

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
72. Alcohol	____	____	*75. Marijuana/hashish*	____	____	*78. Inhalants*	____	____
73. Cocaine/crack	____	____	*76.Sedatives/tranquilizer*	____	____	*79. Tobacco/cig.*	____	____
74. Narcotics/heroin codeine	____	____	*77. Amphetamines/diet pill*	____	____	*80. Other*	____	____

81. Significant Findings

82. COORDINATOR'S SIGNATURE _____ 83. DATE __ __ - __ __ - __ __ __ __

DMAS-50 rev. 06/03

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

Instructions for Completing Form

1. Enter Recipient's Last Name. **Required.**
2. Enter Recipient's First Name. **Required.**
3. Enter Recipient's Middle Initial. **Required.**
4. - 7. Enter Recipient's Address. **Required.**
8. Enter Recipient's Medicaid ID Number. (NOTE: Enter the infant's number, not mother's, if recipient is an infant) **Required.**
9. Enter the Birthdate of the Recipient in MM-DD-CCYY format. **Required.**
10. Circle the appropriate code for the Recipient's Occupation: **Required.**
    - 0 None (Attends school)
    - 1 Not heavy work (Any work outside the home, or in the home for pay, full time or part time, not included under heavy work.)
    - 2 Heavy work (Any work involving strenuous physical effort)
    - 9 Unknown
11. Circle the appropriate code for the Recipient's Marital Status: **Required.**
    - 0 Married
    - 1 Unmarried (single, separated or divorced)
    - 9 Unknown
12. Circle the highest Education Level reached by the Recipient: **Required.**
    - 0 High School graduate or higher
    - 1 9th to 12th grade
    - 2 8th grade or less
    - 9 Unknown

13. Enter the number of Live Births the mother has had.

14. Enter the number of Abortions the mother has had.

15. Enter the number of Miscarriages the mother has had.

16. Enter the number of Stillbirths the mother has had.

17. Enter the Estimated Date of Confinement (EDC) in MM-DD-CCYY format. **Required.**

18. Enter the number of Weeks gestation at which prenatal care began. **Required.**

19. Enter the Provider Name. **Required.**
20. Enter the Provider's Medicaid ID Number. **Required.**
21. Enter the date of the home visit in MM-DD-CCYY format. **Required.**

22. - 62. Assessments

Check "YES" if the indicated problem is a risk for the recipient. Check "NO" if it is not. (NOTE: Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** type apply only to infants.)

63. - 80. Substance Abuse Usage

Enter the **number** of days per week and the **number** of times per day the recipient uses or used each substance. If the recipient does not use the substance, leave the lines blank. If an entry is made in field 71 (Other), the name of the substance/drug must be listed.

81. Enter any Significant Findings discovered during the assessment.
82. Coordinator' Signature. The BabyCare Coordinator must sign the form. **Required.**
83. Date. The BabyCare Coordinator must date the form. **Required.**

For more complete information on BabyCare policy and procedures, please refer to the BabyCare.Manual

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

Page ____ of ____

SERVICING PROVIDER INFORMATION

Number: 4

Name: 5

Contact Person: 6

Phone: 7

Enrollee ID# : 8

Enrollee Name:

Last: 9

First: 10

MI: 11

Referring Provider # 12

13 ☐ Other Non-Paper Enclosure

14 ☐ X-Rays Enclosed

15 ☐ Photographs Enclosed

Diagnosis Code: 16

PA Number: 17 (If cancellation or change)

PA Service Type: 18

1	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
2	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
3	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
4	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
5	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
6	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	Modifiers (If Applicable) 22	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		

FOR ADDITIONAL PROCEDURES FOR THE SAME PA #, USE AN ADDITIONAL FORM -
ENTER BOXES 4, 5, 12, 13, 14, AND 15 ON EACH ADDITIONAL FORM

29 Provider Signature: _____ 30 Date Signed: _____

DMAS - 351 R 6/03

Instructions For Completion of the DMAS 351 – Virginia Department of Medical Assistance Services "Prior Review and Authorization Request" Form

The DMAS 351 is to be used when requesting a new prior authorization, to request a change an existing authorization, or to cancel an existing authorization. Note: A cancellation request can only be honored if there has been no claims activity posted against the authorization.

HEADER DATA

1 – 3	Put an "X" in the box next to the type of request being submitted.
4 – 7	Servicing Provider Information: includes provider ID #, name, , a contact person's name, and telephone number.
8 – 11	Enrollee (Patient) Information: includes enrollee ID#, last name, first name, middle initial.
12	Referring Provider ID # (if applicable).
13 – 15	Indicate if attaching a non-paper enclosure, x-ray, or photograph for review.
16	Enter the primary diagnosis code for the enrollee.
17	Enter the PA Number (tracking number) if requesting a change or cancellation.
18	Enter the appropriate PA Service Type. (See listing in Provider Manual with these instructions.

LINE ITEM DATA

Each form will accommodate up to 6 lines of requests for authorization of services or equipment. If more than 6 lines are needed, use additional DMAS-351's to request additional services or equipment. Be sure to indicate the number of the pages being submitted (top right), especially if more than one DMAS-351 is required.

19 – 25	Indicate the type of procedure code, the procedure code, up to 4 modifiers (if applicable), the number of units requested, amount requested, and a description of the item/service requested.
26	Enter the line # for which you are requesting a change or cancellation.
27 – 28	Enter the From Date and To Date of Service
29 – 30	Provider's signature and date signed.

ATTACHMENTS

Attach required and supportive medical documentation to the completed DMAS-351 and submit to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation

2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA # (if known)

3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐	Line 6 ☐
Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐	Line 11 ☐	Line 12 ☐
Line 13 ☐	Line 14 ☐	Line 15 ☐	Line 16 ☐	Line 17 ☐	Line 18 ☐

PROVIDER INFORMATION

Number: 5 _____

Name: 6 _____

Contact Person: 7 _____

Phone: 8 _____

Enrollee ID# : 9 _____

Enrollee Name:

Last: 10 _____

First: 11 _____

MI: 12 ☐

13 ☐ Other Non-Paper Enclosure

14 ☐ X-Rays Enclosed

15 ☐ Photographs Enclosed

16 ☐ Dental Models Enclosed

PA Service Type: 17 _____

18 COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE, ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

19 Provider Signature _____ 20 Date Signed _____

Instructions For Completion of the DMAS-361
Virginia Department of Medical Assistance Services
"Prior Review and Authorization Request Supporting Documentation"

The DMAS-361 is to be used when returning requested documentation in response to a pend, to request reconsideration of an adverse prior authorization decision, or if sending in orthodontic models separate from the prior authorization request. This form and applicable attachments should be submitted to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

INSTRUCTIONS BY INDICATOR NUMBER:

1. Return Pend Documentation:	Mark with an "X" if returning documentation in response to a pend.
2. Request for Reconsideration:	Mark with an "X" if requesting reconsideration in response to an adverse prior authorization decision.
3. Pending or Denied PA#:	Enter the PA or Tracking Number (if known). If sending in orthodontic models for authorization, leave this field blank.
4. Check appropriate box(es):	Identify which line(s) of the Prior Authorization to refer to.
5. Provider Number:	Enter the provider's Medicaid ID #.
6. Name:	Enter the provider's name.
7. Contact Person:	Enter a Contact's name representing the provider.
8. Phone:	Enter the telephone number at which the Contact can be called.
9. Enrollee ID #:	Enter the enrollee or patient's Medicaid ID #.
10 – 12 Enrollee Name:	Enter the enrollee for patient's last name, first name and middle initial.
13 – 16 Enclosure Type:	Enter an "X" in the appropriate box to indicate enclosure type.
17. PA Service Type:	Enter the appropriate PA Service Type. (See listing in provider manual.)
18. Comments:	Enter any comments that provide clarification or further information.
19 – 20 Provider Signature & Date	The provider must sign and date the form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name

04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 21. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 6, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

INDEX

Attachment 4 – Remittance Advice (RA) Examples

Attachment 5 - Forms